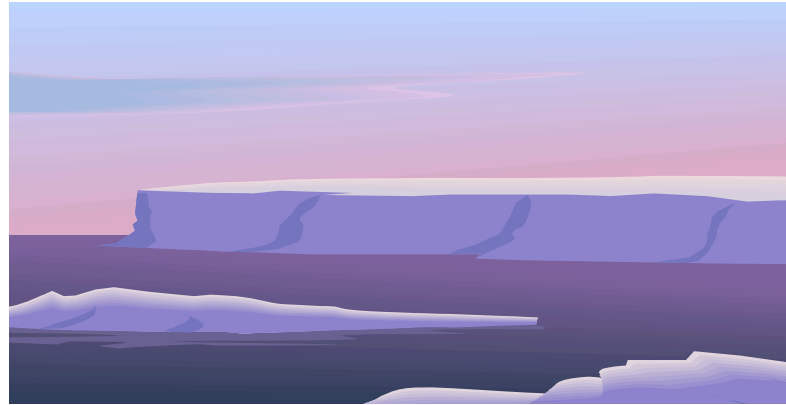


Disparities in Patient-centered Care: Let's Talk About It



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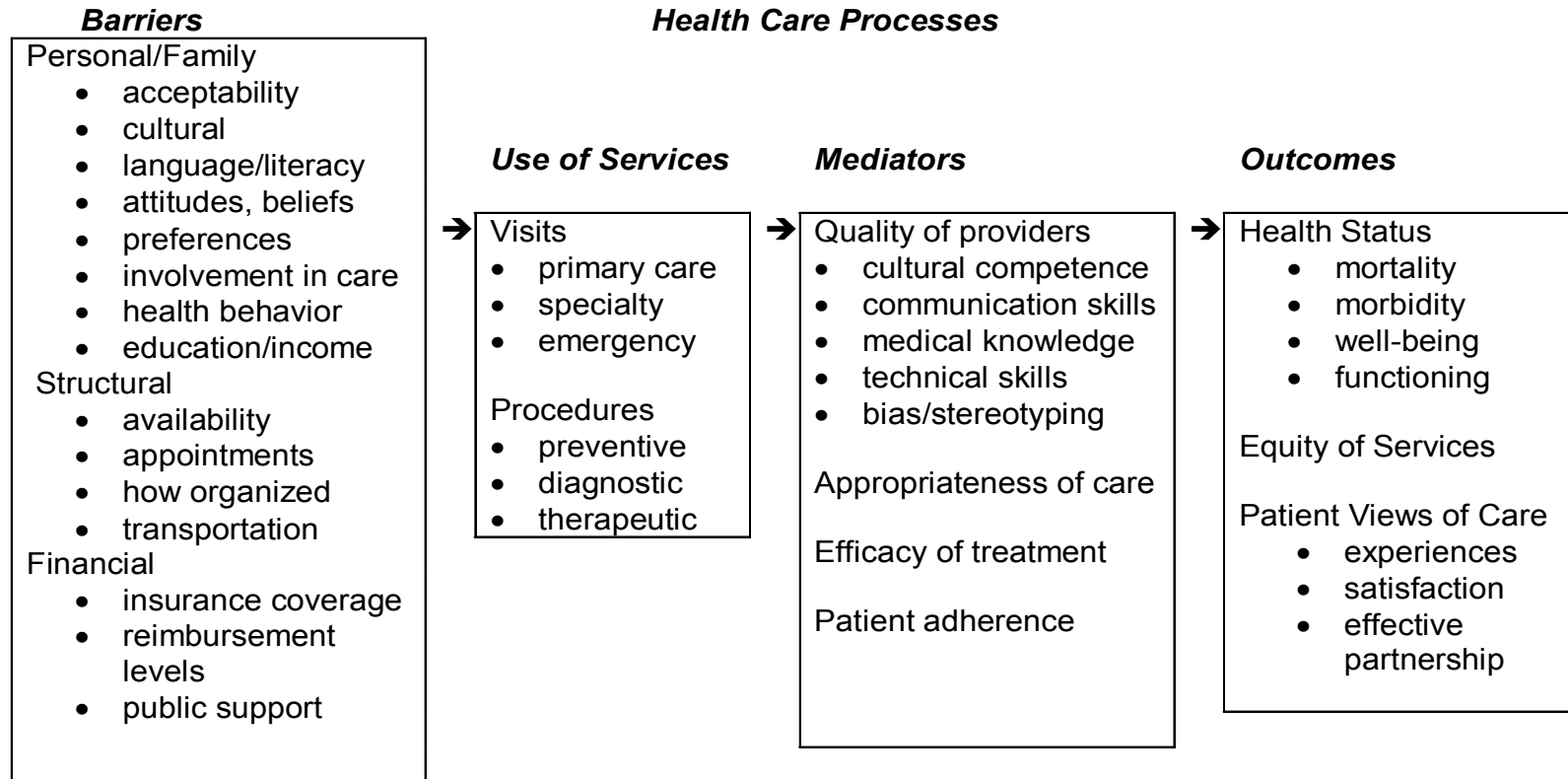
Objectives

1. Describe important differences in communication (patient-centered interpersonal care) that exist between the visits of ethnic minority and majority primary care patients
2. Identify the major communication differences between visits where physicians and patients are ethnically concordant versus discordant
3. Identify key clinical, educational, and health system strategies for overcoming racial and ethnic disparities in patient-centered care

Healthcare disparities are pervasive

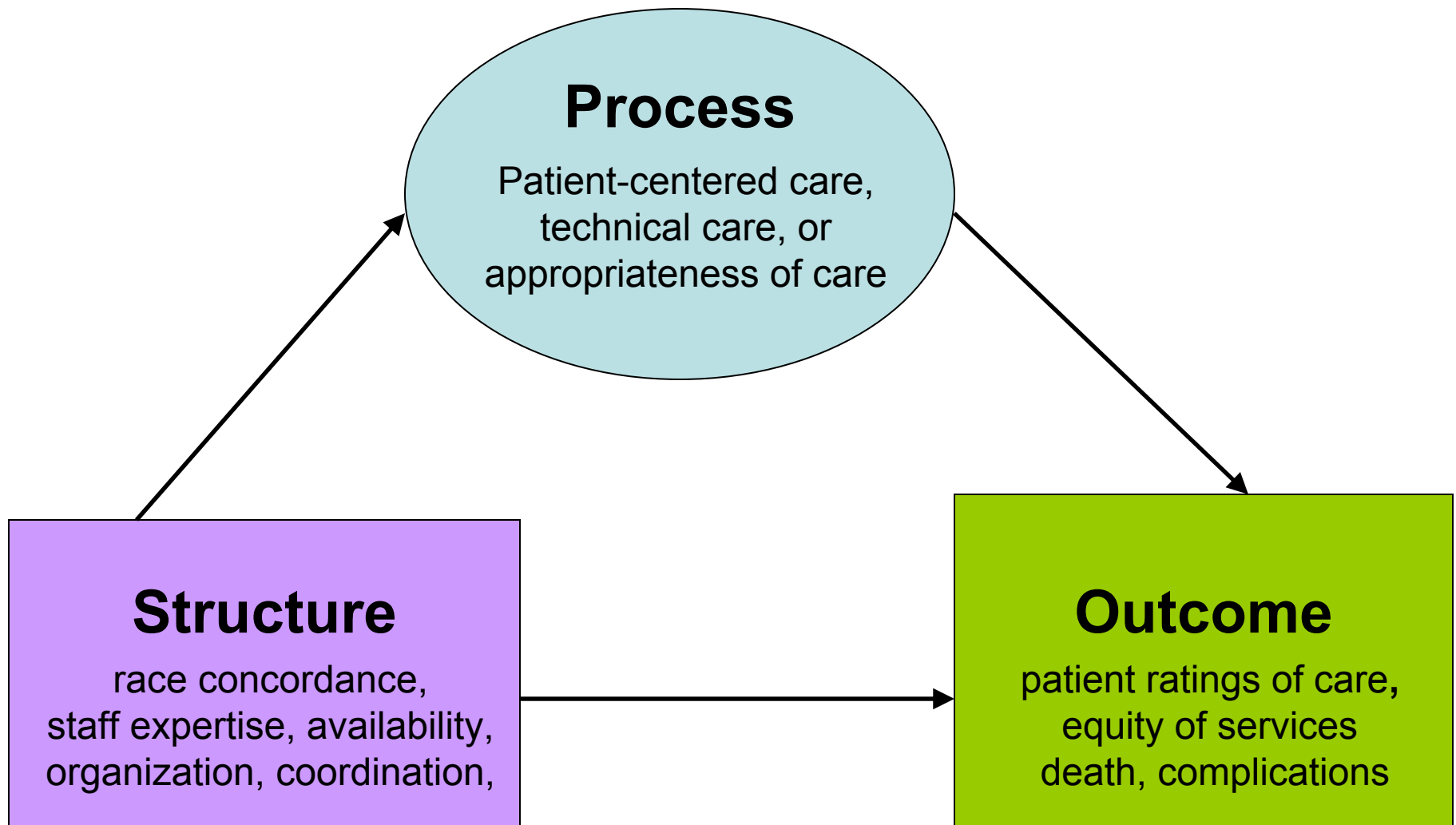
- *Conditions*: cancer, diabetes, heart disease, kidney disease, HIV/AIDS, mental health, respiratory diseases
- *Populations*: young, old, women, urban, rural
- *Settings*: primary care, emergency care, hospital care, specialty care, nursing homes
- *Levels and types of care*: preventive, acute care, chronic disease management
- *Dimensions of quality*: effectiveness, patient safety, timeliness, and patient-centeredness

Achieving Equitable Health Care for Racial and Ethnic Groups



Dimensions of Health Care Quality

- **Structure:** “characteristics of the settings in which care is delivered...”
- **Process:** “ ...the care itself, or activities undertaken by the health care system...”
- **Outcome:** “the effect of care on the health and welfare of individuals or populations...”



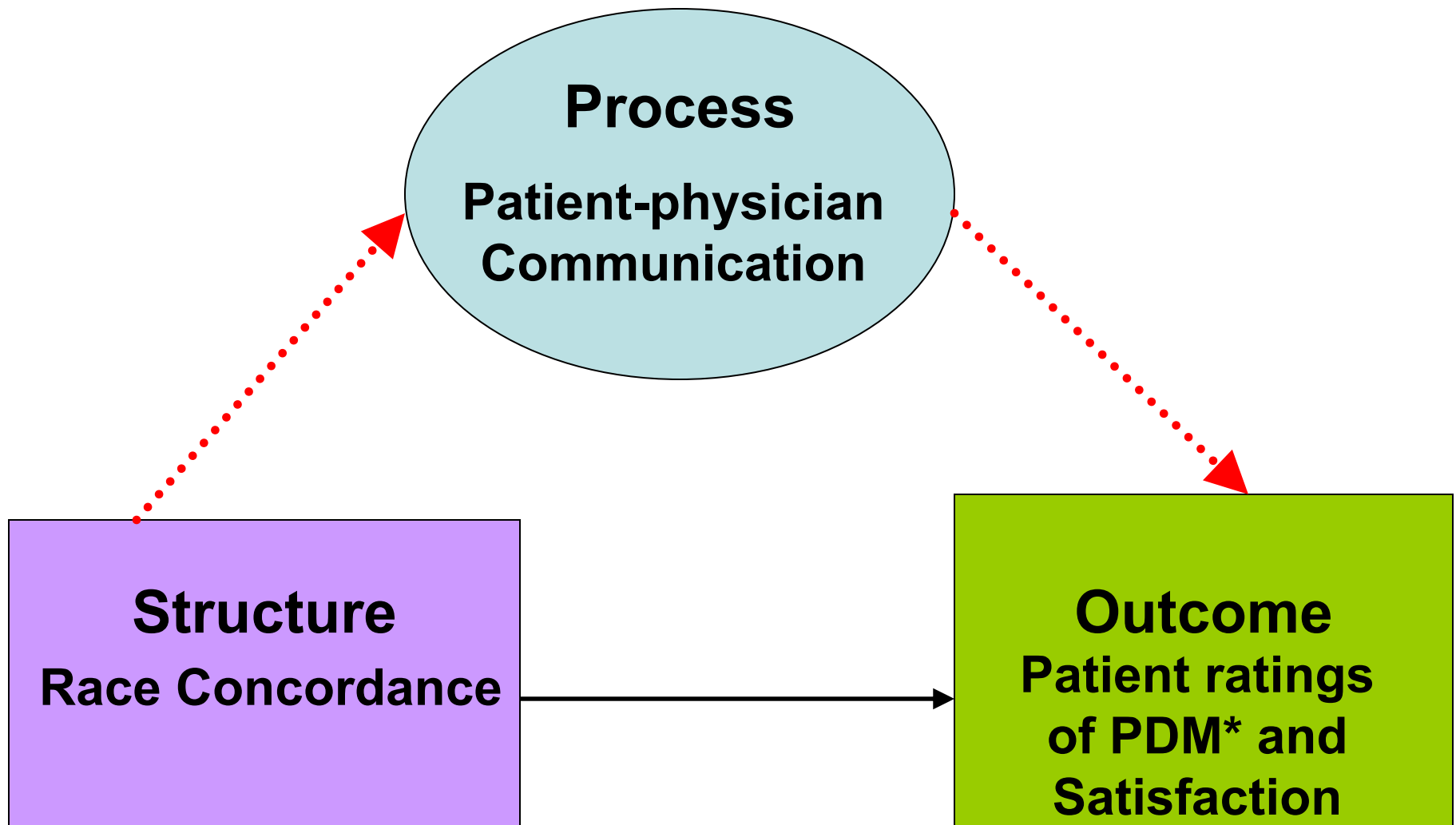
Examples of Structure, Process, and Outcome Variables

Health Care Process

- Patient-centered care: care that responds to the wants, needs, and preferences of patients and their families and allows them to participate in decisions about their care
- Technical care: physical exams, tests, procedures, and medications
- Appropriate care: care that has been documented in research studies to improve patient health outcomes

Disparities in Process of Care

- Technical care – many studies
 - Ethnic minorities receive fewer preventive services, diagnostic and therapeutic tests and procedures, and fewer appropriate medications
- Patient-centered care – few studies
 - Ethnic minorities have lower levels of trust in physicians and hospitals and report less respectful treatment and less participation in health care decisions
- Few disparities studies make links between structure, patient-centered care, and outcomes



* physicians' participatory decision-making style

Concordance

- What is it?
 - a structural dimension of health care quality
 - shared identities between patients and health professionals
- Why do we care?
 - Because most ethnic minorities see physicians who differ from them in key social characteristics
- Patients and physicians may be concordant in:
 - Visible demographic factors such as race/ethnicity, gender, age, education, social class, language
 - Less visible factors below the tip of the cultural iceberg such as beliefs, values, expectations, preferred roles

Patient-physician communication is patient-centered care at the interpersonal level

- Data-gathering
- Educating and counseling
- Relationship-building
- Partnering with patients to negotiate diagnostic and treatment decisions



Lipkin, Putnam, & Lazare, 1995

Patient-physician communication is related to important outcomes

- Patient recall of information
- Patient adherence
- Patient satisfaction
- Clinical outcomes
 - Glycemic control
 - BP control
 - Pain reduction
 - Depression resolution



Roter 1988, Greenfield 1988, Kaplan 1989, Stewart 1995, Kaplan 1995

Patient-Centered Communication, Ratings of Care and Concordance of Patient and Physician Race

- Design: brief cohort study using pre-visit and post-visit surveys and audiotape analysis
- Setting: urban primary care practices serving managed care and fee-for-service patients
- Participants: African American and white adult patients receiving care from primary care physicians
- Patient recruitment: ~10 patients per MD recruited consecutively from waiting rooms

Cooper LA, Roter DL, Johnson RL, Ford DE, Steinwachs DM, Powe NR.

Ann Intern Med 2003;139:907-915

Measurement of Physician-Patient Communication*

- Content
 - Question asking - Biomedical information
 - Psychosocial talk - Depression talk
- Affect
 - Emotional Talk - Negative talk
 - Positive talk - Social talk
- Process
 - Orientation (directions or instructions)
 - Facilitation (includes partnership-building)

*Roter Interaction Analysis System (RIAS)

Examples from RIAS

Communication Categories

- Biomedical talk

“Your blood pressure is 100 over 70.”

“I was in the hospital last year for ulcers.”

- Psychosocial talk

“You really need to get out and meet more people.”

“I guess every marriage has its ups and downs.”

- Emotional talk

“This must be very hard for you.”

“I hope you’ll be feeling better soon.”

- Partnership-building

“Do you follow me?” “How does that sound to you?”

Measuring Emotional Tone of Visits using the RIAS

Coders are asked to rate overall emotional tone of the visit for patients and physicians:

- **Patient positive affect** = (assertiveness + interest + friendliness + responsiveness + empathy)
- **Physician positive affect** = (interest + friendliness + responsiveness + empathy) - hurried

Patient-Centered Communication

- Longer visits
- Slower speech by patients and physicians
- Less physician verbal dominance (ratio of all doctor to all patient talk)
- Higher patient-centeredness ratio: more psychosocial and emotional statements relative to biomedical statements; more partnership-building statements
- More positive emotional tone or affect

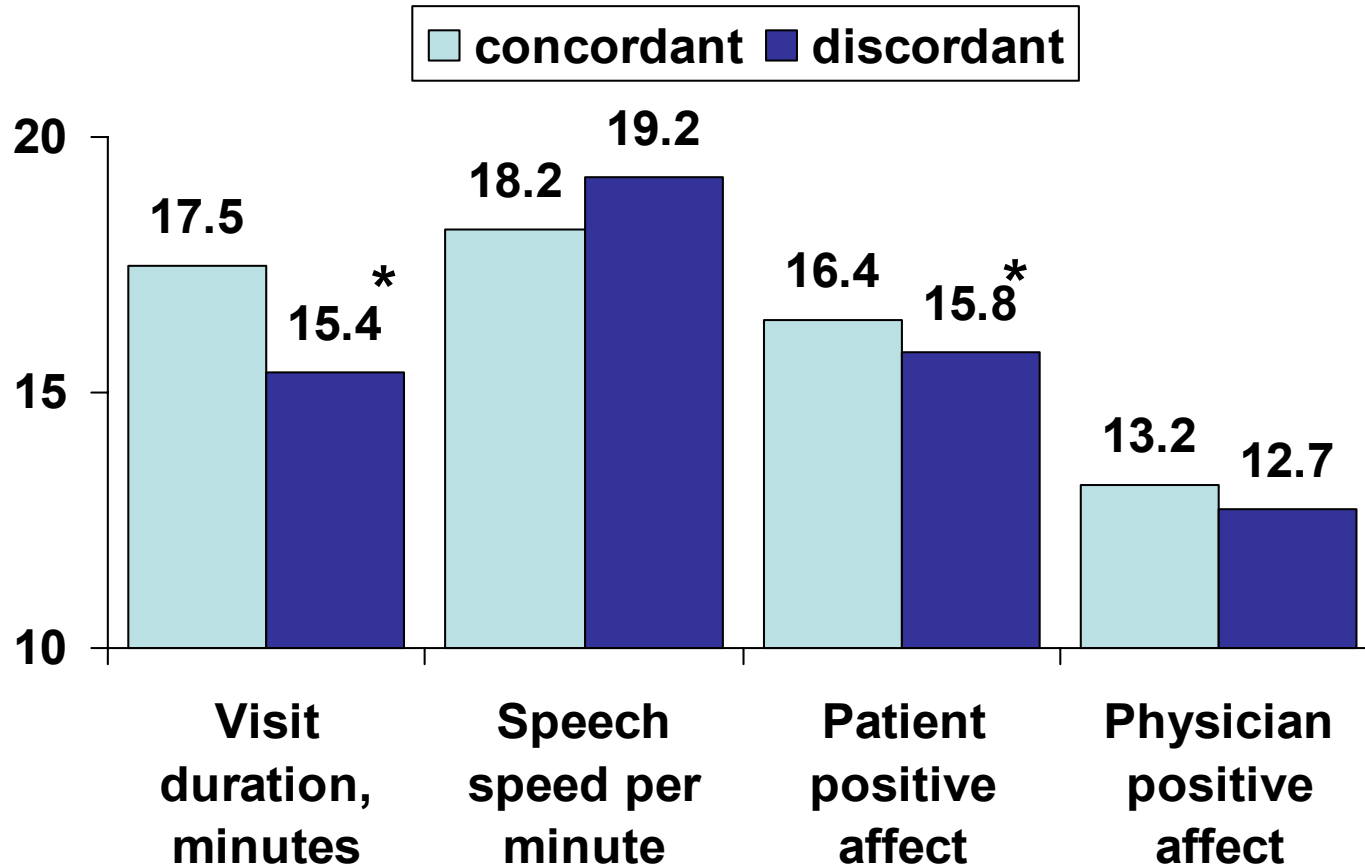
Physicians are more verbally dominant and have less positive emotional tone in visits with African-American patients

Communication measure	Whites n=202	Blacks n=256	p-value*
Physician verbal dominance	1.50	1.73	<0.01
Patient-centeredness ratio	1.91	1.58	0.08
Patient positive affect**	16.7	15.8	<0.01
Physician positive affect**	14.1	13.2	0.02

Adjusted for: patient age, gender, education level, and self-rated health status; and physician gender, race, time since completing training, and report of how well he/she knows each patient.

*p-value from linear regression with GEE.** Patient and physician affect scores are derived from audiotape coders' impressions of the overall emotional tone of the medical visit.

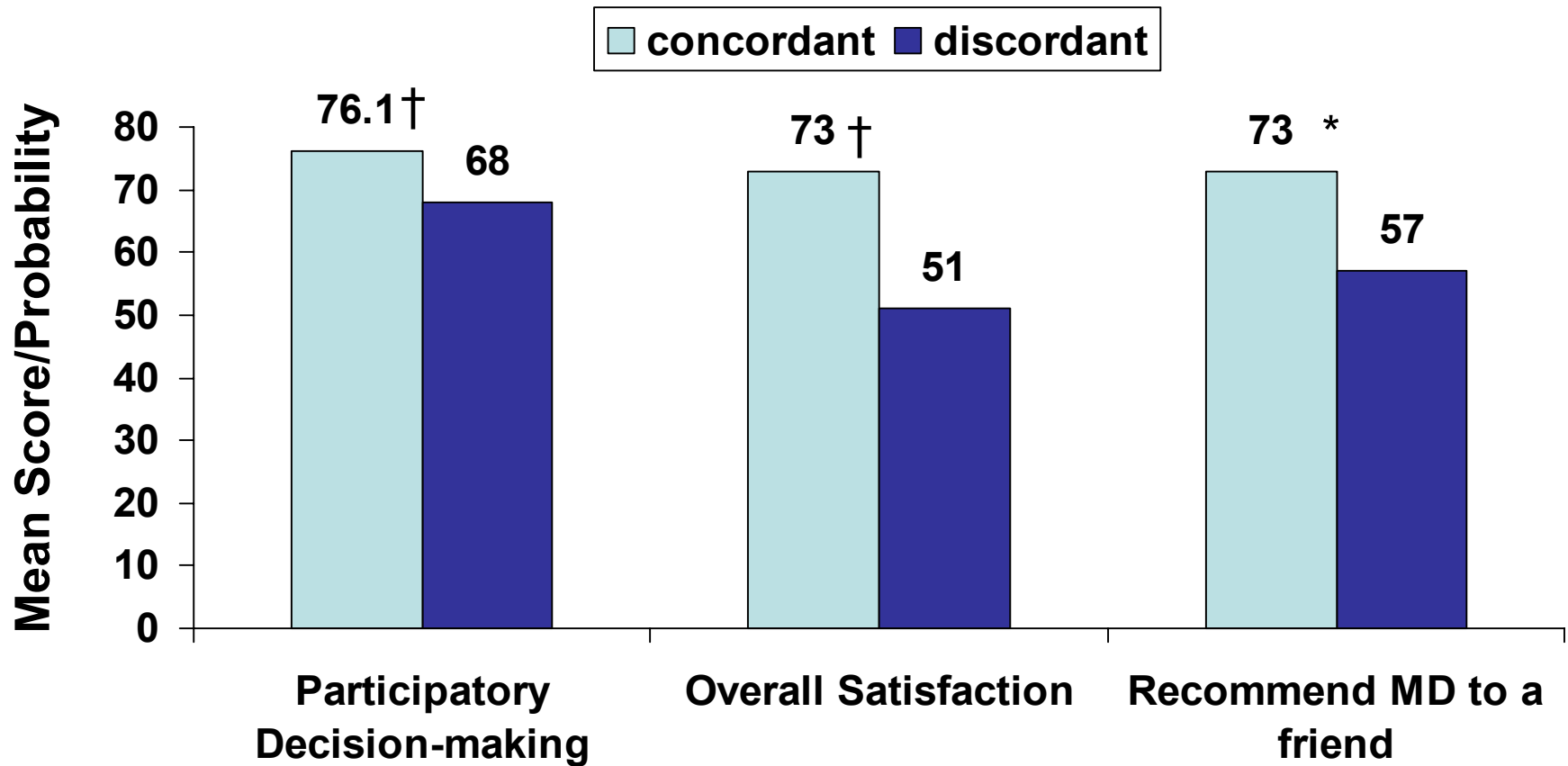
Race-concordant visits are longer with more positive patient emotional tone



* $p < 0.05$. Adjusted for patient age, race, gender, and health status and physician gender and years in practice.

Cooper LA et al, Ann Intern Med 2003;139:907-915

Patients in Race-Concordant Relationships Rate Their Physicians Better Regardless of Communication



* $p < 0.05$, † $p < 0.01$ from GEE. Analyses adjusted for patient gender, race, age, and health status, physician gender, years in practice, and *patient-centered communication*.

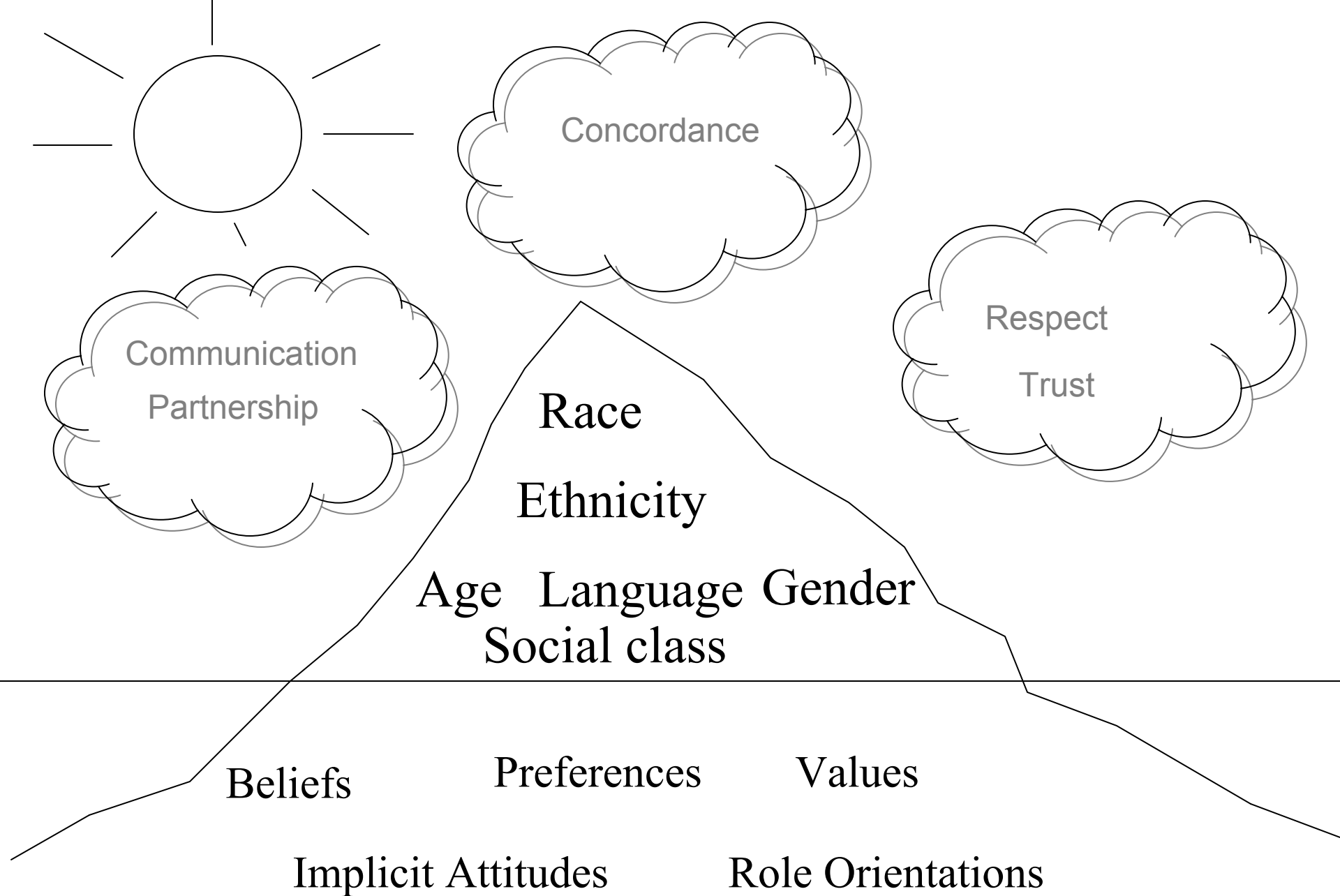
Cooper LA et al, Ann Intern Med 2003;139:907-915

Summary

- African-American patients experience less participatory and less friendly visits with physicians
- Race-concordant visits are:
 - Longer with slower pace of speech
 - More positive (doctors and patients sound happier and more interested)
 - More satisfactory to patients
 - Perceived as more participatory by patients

Summary (cont'd)

- Communication differences do not completely explain why patients in race concordant relationships rate their physicians better
- This suggests that other physician and patient attitudes (e.g., bias, mistrust, cultural misunderstanding) may be contributing to the problem



Iceberg Concept of Culture Applied to Race Relations in Healthcare.
Cooper LA et al. J Gen Intern Med 2006; 21:S21-27.

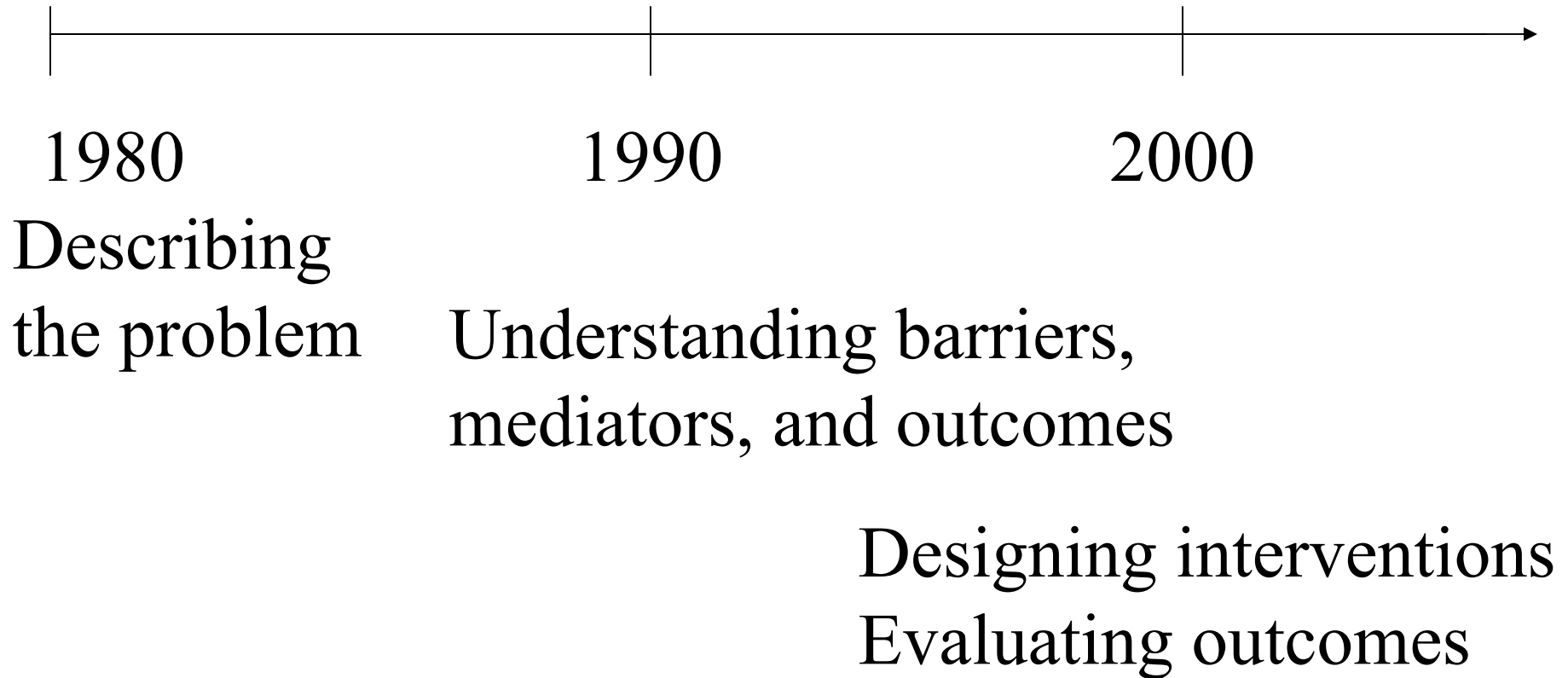
Implications

- Clinical Practice
 - Implement patient activation programs
 - Improve scheduling and increase time available to build rapport and develop continuity of care
- Education and Training
 - Employ communication skills training for students, residents, and practicing physicians
 - Emphasize rapport building/affective dimensions
 - Enhance intercultural awareness and skills

Implications

- Research
 - Better measurement of patient and physician attitudinal factors, e.g., bias, ethnocentricity
 - Quantify impact of disparities in patient-centered care on health outcomes
- Policy
 - Increase numbers of underrepresented ethnic minorities among health professionals
 - Provide ethnic minority patients with more choices regarding providers and sites of care
 - Improve access to and experiences of care

Evolution of Research on Health Care Disparities





Patient-Physician Partnership to Improve HBP Adherence

- Design: Randomized controlled trial with 2x2 factorial design
- Population: 42 MDs and 279 ethnic minorities and poor persons with high blood pressure (HBP)
- Setting: 18 urban community-based clinics in Baltimore, Maryland
- Interventions: Communication skills training on interactive CD-ROM for MDs; Patient activation by community health worker

Supported by the National Heart, Lung, and Blood Institute

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Outcomes

- Patient-physician communication behaviors
- Patient ratings of care
- Patient adherence
 - Appointment-keeping (administrative data)
 - Prescription refill rates (automated pharmacy records)
 - Pill counts
 - Self-reported adherence to meds, diet, and exercise
- Appropriateness of hypertension care (JNC-7)
- Hospitalizations and ER visits
- Health outcomes (BP and diabetes control)